



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SELECT SPECIALTY HOSPITAL
4716 OLD GETTYSBURG ROAD
MECHANICSBURG PA 17055

Carrier's Austin Representative Box

#54

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Date Received

MAY 8, 2007

MFDR Tracking Number

M4-07-6169-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated May 3, 2007: "We have submitted the attached claim...to insurance carrier Texas Mutual for an inpatient long term acute care hospital stay. We are appealing the timely filing denial we received from Texas Mutual. The dates of service for the inpatient stay were from 4/1/06 through 10/13/06. In understand that TX WC regulations require billing of clean claim to be submitted within 95 days from date service were provided. For the reasons listed below we are requesting that the discharge date be used as the date service were provided in relation to our entire claim.

- Medicare guidelines require LTACH inpatient services to be billed upon discharge, as one claim, including all charges from admission through discharge.
- TX WC regulations also compute reimbursement using the length of entire stay in their calculations, as well as, a stop loss calculation which requires total charges for the entire admission in order to be computed correctly.
- Services where [sic] not concluded until patient discharged on 10/13/06.

Based upon the above the 95th day the claim needed to be filed by would have been 01/17/07. Attached is proof that a clean claim was received by the insurance carrier on 01/3/07."

Requestor's Supplemental Position Summary Dated March 10, 2009: "Per our conversation today, March 10, 2009, Select Specialty Hospital respectfully withdraws the complaint for dates of service 4/1/2006 through May 7, 2006 only. Select Specialty Hospital would like to continue the review/dispute for dates of service May 8, 2006 through discharge of October 13, 2006."

Amount in Dispute: \$131,185.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated June 6, 2007: "This dispute involves whether Texas Mutual's payment is subject to stop loss for date of service 4/1/2006 to 10/13/2006. The requester billed **\$271,022.82**; Texas Mutual paid **\$72,081.46**. The requester believes it is entitled to an additional **\$131,185.66**...Texas Mutual has no record of receipt of a complete medical bill received for ALL dates of service listed on this claim prior to on or before the 95th day after the date of service (which is 7/5/2006 – 1/16/2007); therefore, it is Texas Mutual's position that a portion of the listed services in dispute was untimely filed. Records submitted do not reflect that the requestor

filed ALL its services within the 95th day after the date of service to this insurance carrier; therefore, the requestor was not complaint with DWC Rule 134.801. Given the above, Texas Mutual believes no further payment is due.”

Respondent’s Supplemental Position Summary Dated September 8, 2011: “The requestor identifies itself as a long term care hospital (LTCH)...Further, the requestor indirectly alludes to the ‘stop loss calculation’ in its DWC-60 packet. Stop-loss applies to acute care inpatient admissions that correspond to a certain range of diagnosis codes. An LTCH is not subject to an acute care payment methodology but instead is paid at a fair and reasonable rate. The requestor wants a stop-loss payment that it is not entitled to. Texas Mutual paid \$72,081.46 as a fair and reasonable payment for those days of the billing cycle timely. The requestor’s DWC-60 packet contains no persuasive information substantiating its position (a) the 95 day bill submission requirement should be waived because it is an LTCH or (b) that it is entitled to payment under the stop-loss method. Therefore, no additional payment is due.”

Responses Submitted by: Texas Mutual Insurance Company, 6210 East Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
May 8, 2006 Through October 13, 2006	Inpatient Hospital Services	\$131,185.66	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers’ Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
4. Texas Labor Code §408.027, effective September 1, 2005, sets out the deadline for timely submitting the medical bills to the insurance carrier.
5. 28 Texas Administrative Code §133.20, effective May 2, 2006, sets out the timeframe for healthcare providers to submit a medical bill.
6. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out the rules for non-Commission communications.
7. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits December 5, 2006

- CAC-W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- CAC-29 – The time limit for filing has expired.
- 426 – Reimbursed to fair and reasonable.
- 731 – 134.801 & 133.20 provider shall not submit a medical bill later than the 95th day after the date of service, for service on or after 9/1/05.

Issues

1. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a), and 28 Texas Administrative Code §133.20(b)?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §133.20(b) states "A health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

28 Texas Administrative Code § 102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

The requestor states in the position summary "Attached is proof that a clean claim was received by the insurance carrier on 01/3/07."

The respondent states in the position summary "...it is Texas Mutual's position that a portion of the listed services in dispute was untimely filed."

The Division finds that the respondent submitted a certified mail receipt received by the respondent on January 3, 2007."

This letter supports the requestor's position that the disputed bill was submitted within 95 days required by Texas Labor Code §408.027(a), and Division rule at 28 TAC §133.20(b) for dates of service September 30, 2006 through October 13, 2006. The requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for dates of service May 8, 2006 through September 29, 2006.

2. The services in dispute are long term care hospital services. 28 Texas Administrative Code §134.401(a)(2) states "Psychiatric and/or rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline on these specific types of admissions."

Former 28 Texas Administrative Code §134.1, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Former 28 Texas Administrative Code §133.307(c)(2)(G, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor states in the Appeal Request Letter "IF AUDITED CHARGES EXCEED THE STOP-LOSS THRESHOLD, REIMBURSEMENT FOR THE ENTIRE ADMISSION SHALL BE PAID USING A STOP-

LOSS REIMBURSEMENT FACTOR (SLRF) OF 75%.' ACCORDING TO THIS METHODOLOGY, THE TOTAL PAYMENT IS DUE FOR THIS CLAIM IS \$203,267.12."

- The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(6).
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ 3/7/2013 Date
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_____ Signature	_____ Health Care Business Management Director	_____ 3/7/2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.